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PATIENT RACE AND PATIENT-PHYSICIAN RACE CONCORDANCE IN THE MANAGEMENT AND TREATMENT OF CVD FOR PATIENTS WITH DIABETES: A TRIAD STUDY

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BACKGROUND: Intimate partner violence (IPV) against women has an estimated lifetime prevalence of 22–57%. Women who experience IPV have higher health care utilization rates and are more likely to rate their health as poor compared to those women who had never experienced IPV. Intimate partner violence (IPV) has been identified as a risk factor for a number of physical and emotional health problems. A hospital-based, inter-disciplinary clinic (VIVA) was established to address the needs of IPV survivors by facilitating access to mental and physical health services and community resources in one location. A retrospective review of women referred to the VIVA clinic demonstrated that women who visited the clinic were offered more resources (mean 4.5) as compared to women referred to the VIVA clinic but who never came (mean 2.6 resources). Over half of the women given a referral to the VIVA program never came. Limited data exists on victims' perceptions of needed services and on the outcomes of hospital-based intervention programs such as the VIVA clinic. This study sought to evaluate the services of the VIVA clinic from the perspective of the women served in order to meet the needs of IPV survivors with an optimal patient-centered approach.

METHODS: The study used a qualitative approach with individual semi-structured interviews (demographics and 10 open-ended questions) of eligible participants. All women who visited the VIVA clinic for a return appointment during the study period were invited to participate. To ensure adequate saturation of topics and themes, a convenience sample of the first ten English and ten Spanish-speaking patients willing to participate were interviewed in a private room. Interviews were audio recorded, translated, and transcribed. The transcripts were coded for themes independently by three researchers and then were evaluated by all of the researchers for congruence of themes.

RESULTS: All 20 women approached agreed to participate. The average age of participants was 43.5 years. English-speaking IPV survivors identified readiness for change, desire to gain knowledge and access to resources as factors that were influential on attending a sub-specialty clinic for survivors of domestic violence. Spanish-speaking IPV survivors found the desire for treatment of depression and their "children" as influential to attending the VIVA clinic. Both English and Spanish-speaking patients identified fear of the perpetrator as a perceived barrier to clinic attendance for survivors in general. English speakers also identified shame as a potential barrier to help seeking. Clinic visitors found benefit in the availability of mental health and medical care during the same clinic appointment. When asked how the VIVA clinic services affected them, many of the participants commented positively on the patient-professional relationship such as "trust" "confidence" "confidentiality." Survivors who attended the clinic identified the need for timely service and alternate clinic hours (weekends, evenings) due to work and child care obligations.

CONCLUSION: Fear, shame and readiness for change are influential in accessing care at the VIVA clinic, a sub-specialty clinic for survivors of intimate partner violence. Women perceived benefits from the "art of listening" offered by professionals who were knowledgeable about IPV.

PATIENT PERSPECTIVES ON MANAGING HYPERTENSION: DEVELOPING A NEW CONCEPTUAL MODEL OF PATIENT BEHAVIOR B.G. Bokhour¹; J. Solomon¹; E.C. Cohn²; D. Cortes³; A. Elwy¹; P. Haidet⁴; L.A. Katz⁵; A. Borzecki⁶; A.R. Green⁷; N.R. Kressin⁸.

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BACKGROUND: With up to 30% of patients having uncontrolled hypertension, finding novel ways to improve upon patients' hypertension self-management is a priority. The role of patient perspectives, beliefs and practices in hypertension management remains poorly understood. We sought to develop a more comprehensive conceptual model of patient hypertension management.

METHODS: We conducted semi-structured qualitative interviews with 55 white, Latino and African-American patients with uncontrolled hypertension at two large Veterans Affairs Medical Centers. Fully transcribed interviews were analyzed using grounded theory analytic methodology, including open and axial coding, theorizing and constant

comparison analysis across cases. Conceptual models were iteratively developed and refined through review of individual cases.

RESULTS: We identified four domains which affected the actions patients took to manage their hypertension: 1) Explanatory models – beliefs that individuals have regarding the cause, mechanisms & course of illness, and effects of treatment; 2) Planned action – patients' reported plans and motivations to control their hypertension; 3) Daily lived experience – patients' context, routines and other health problems that affect hypertension management; and 4) relationship with provider – including patients' attitudes towards their provider and provider communication. A breakdown in one or more of these areas were found to interfere with the patients' ability to engage in accepted hypertension control behaviors such as watching their diet, exercising, or taking prescribed medications. For example, many patients believed that stress was the primary reason their blood pressure would rise, and thereby their primary actions to control BP were managing stress. Other patients recognized the impact of hypertension and how they could manage it, but their daily lived experiences interfered due to few routines in their lives or social isolation. Patients rarely reported provider discussions about such issues in their clinical encounters.

CONCLUSION: In order to improve hypertension control, providers need to address patients' understandings of hypertension, their daily lived experience in managing hypertension as well as their motivations for controlling their hypertension. Simply providing information about hypertension and prescribing appropriate medications may be inadequate if other aspects of patients' belief systems and daily lived experiences interfere with their ability to follow through on recommendations. The conceptual model we have developed has implications for the ways in which we counsel patients about management of hypertension as well other chronic diseases. Designing interventions which include all aspects that contribute to patients' actions to control hypertension may lead to better overall blood pressure control and patient health.

PATIENT RACE AND PATIENT-PHYSICIAN RACE CONCORDANCE IN THE MANAGEMENT AND TREATMENT OF CVD FOR PATIENTS WITH DIABETES: A TRIAD STUDY A. Traylor¹; U. Subramanian²; C. Uratsu³; C.M. Mangione⁴; J. Schmitt⁵. ¹University of California, Berkeley, Berkeley, CA; ²Indiana University Purdue University Indianapolis, Indianapolis, IN; ³Kaiser Permanente Division of Research, Oakland, CA; ⁴University of California, Los Angeles, Los Angeles, CA; ⁵Kaiser Permanente Northern California Division of Research, Oakland, CA. (Tracking ID # 205261)

BACKGROUND: There are well-documented racial disparities in cardiovascular (CVD) outcomes for patients with diabetes. However, the evidence on whether patients of color receive worse care for controlling CVD risk factors is mixed. Cultural or interpersonal barriers to the patient-physician relationship may contribute to CVD disparities. Studies have shown that patient-provider race concordance (defined as the patient and health care provider having the same race) can improve the interpersonal care received by minority patients. However, the effect of race concordance on CVD care and prevention is unknown. The purpose of this analysis is to examine the association of patient race and patient-provider race concordance on CVD risk factor levels and appropriate modification of treatment in response to high risk factor values (treatment intensification) in a large cohort of diabetes patients in an integrated delivery system.

METHODS: A cohort of 108,555 black, white, and hispanic adult diabetes patients in Kaiser Permanente Northern California (KPNC) in 2005 served as the study population. Good risk factor control in 2005 was defined as A1c < 8.0%, LDL-c < 100 mg/dL, and two or more consecutive systolic blood pressures (SBP) < 140 mm Hg throughout 2005 respectively. Treatment intensification was defined as an increase in the number of drug classes, an increase in dosage of at least one drug class, or a switch to a different drug class within six months of an elevated risk factor value. Lab, blood pressure values, and evidence of treatment intensification were obtained through KPNC clinical, laboratory, and pharmacy databases. Probit models were conducted to assess the effect of patient race on A1c, LDL-c and SBP control and treatment intensification after adjusting for other patient and physician-level characteristics. Stratified probit models for Black, Hispanic and White patients assessed the effect of patient-physician race concordance on A1c, LDL-c and SBP control and intensification within each subgroup

separately. To account for patient clustering at the physician level, all models adjusted for physician random effects.

RESULTS: Adjusted models showed that Black patients were less likely than Whites to have A1c <8.0% (64% versus 69%, p<.0001). Black patients were also less likely to have LDL-c <100 (40% versus 47%, p<.0001) and SBP<140 (70% versus 78%, p<.0001). Hispanic patients were less likely than Whites to have A1c<8% (62% versus 69%, p<.0001). Black patients were less likely than Whites to have A1c intensification (73% versus 77%, p<.0001) and LDL-c intensification (44% versus 47%, p<.0001). However, Black patients were most likely to receive treatment intensification for SBP (78% versus 71% p<.0001). No significant disparities in treatment intensification for any risk factors were found for Hispanic patients. Patient-physician race concordance was not significantly associated with either risk factor control or treatment intensification.

CONCLUSION: Patient race is a significant predictor of risk factor control and treatment intensification. However, in adjusted models, patient-provider race concordance was not associated with either control or treatment intensification for any risk factor. Further research should investigate other potential drivers of racial disparities in CVD care.

PATIENT-LEVEL DETERMINANTS OF DYING IN THE HOSPITAL AMONG HRS DECEDENTS A.S. Kelley¹; S.L. Ettner¹; N.S. Wenger¹; C.A. Sarkisian². ¹University of California, Los Angeles, Los Angeles, CA; ²University of California, Los Angeles/VA Greater Los Angeles Health-care System, Los Angeles, CA. (Tracking ID # 203242)

BACKGROUND: Medical expenses in the last year of life dramatically exceed costs of care during other years and this spending is unsustainable as our population ages. High intensity hospital care at the end of life (EOL) is not associated with improved quality or satisfaction for most patients and their families. Our aim was to examine the patient-level determinants of dying in the hospital, a key indicator of high intensity, high cost EOL care.

METHODS: We sampled all decedents between 2000 and 2006, age 67 and older at the time of death, from the Health and Retirement Study (HRS), a longitudinal nationally representative cohort of older adults. A multivariate logit model was constructed to investigate the relationship between patients' social, functional and health characteristics and the primary outcome, dying in the hospital. Covariate selection was based on a conceptual model developed by the investigators and empirical literature.

RESULTS: Of the sampled HRS decedents (n=3539), 39% died in the hospital, 27% died at home, 26% in a nursing home, and 8% in other locations. Controlling for sociodemographic, functional and health covariates, characteristics associated with lower odds of dying in the hospital included white race and nursing home residence, while independence in activities of daily living and a greater number of medical comorbidities were associated with higher odds. Age, gender, education, net worth, and self-rated health did not have a statistically significant relationship with dying in the hospital. Not living alone, a proxy measure of social support, and having completed an advance directive, had associations with lower odds of dying in the hospital that approached but did not reach statistical significance.

CONCLUSION: Previously unexamined functional and social characteristics are significant correlates of dying in the hospital, a core component of high intensity EOL care. These results in conjunction with further investigation of patient-level determinants of EOL care intensity should help to prospectively identify individuals at risk for unwanted aggressive EOL care. Ultimately these findings should inform interventions to assist physicians and patients in the development of appropriate, preference-guided EOL care plans.

PATIENT-PHYSICIAN LANGUAGE CONCORDANCE AND PRIMARY CARE SCREENING PRACTICES AMONG SPANISH-SPEAKING PATIENTS P.P. Eamranond¹; R.B. Davis¹; R.S. Phillips²; C.C. Wee³. ¹Beth Israel Deaconess Medical Center, Boston, MA; ²Harvard University, Boston, MA; ³Beth Israel Deaconess Medical Center, Brookline, MA. (Tracking ID # 204861)

BACKGROUND: Compared to non-Hispanic whites, Hispanic patients are less likely to undergo Pap smear, mammogram, fecal occult blood test, and sigmoidoscopy. Furthermore, Spanish-speakers are less likely to be screened for hyperlipidemia than English-speakers. We sought to determine whether patient-physician language concordance was associated with differences in cancer and cardiovascular risk factor screening among a Spanish-speaking patient population.

METHODS: We performed a retrospective medical record review of 101 Spanish-speaking patients cared for by 6 Spanish-speaking PCPs (language concordant group) and 205 Spanish-speaking patients cared for by 44 non-Spanish-speaking PCPs (language discordant group). Patients were included in the study if they were age 35-75 and used interpreter services between June 2001 to June 2006 in two Boston-based primary care practices. Our outcomes included screening for hyperlipidemia, diabetes, cervical cancer, breast cancer, and colorectal cancer with age- and sex-appropriate subgroups, as recommended by U.S. Preventive Services Task Force. Our main predictor of interest was patient-physician language concordance. We adjusted for clustering of patients within individual physicians and clinic sites using generalized estimating equations.

RESULTS: Patients in the language-discordant group tended to be female compared to patients in the language-concordant group. There were no significant differences in age, insurance status, # of PCP visits, duration of patient-PCP relationship, body weight, or Charlson comorbidity index between the two groups. Patients with non-Spanish-speaking PCPs tended to have more PCP visits than those with Spanish-speaking PCPs. Rates of screening for hyperlipidemia, diabetes, cervical cancer, and breast cancer were similar for both language concordant and discordant groups (see Table). However, patients in the language discordant group were more likely to be screened for colorectal cancer compared to the language concordant group. Odds ratios did not change significantly with adjusting for clustering by generalized estimating equations.

CONCLUSION: Although matching bilingual PCPs to patients with limited English proficiency has been touted to improve patient care, this study finds that Spanish-speaking patients cared for by language-concordant PCPs were not more likely to received recommended screening for cardiovascular risk factors and cancer.

Patient-Level Determinants of Dying in the Hospital among HRS Decedents

Patient Characteristics, n=3539	Adjusted Odds Ratio*	95% Confidence Interval	p value
Race, White	0.62	(0.50, 0.77)	<0.001
Advance Directive Completed	0.85	(0.71, 1.02)	0.08
Independence in Activities of Daily Living	1.93	(1.58, 2.36)	<0.001
Nursing Home Residence	0.41	(0.34, 0.50)	<0.001
Does Not Live Alone	0.84	(0.70, 1.01)	0.06
Number of Medical Comorbidities	1.09	(1.04, 1.15)	<0.001

* Adjusted for non-significant variables: age, gender, education, net worth, and self-rated health.